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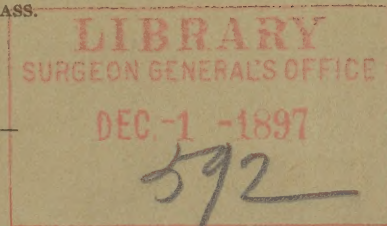
With Compliments of the Author.....

On Cellulitis or Pannicultis Adiposa
and Myitis Occurring as Usual
Complications to Gynecological Diseases.

.... BY

RICHARD HOGNER, M. D.,

BOSTON, MASS.



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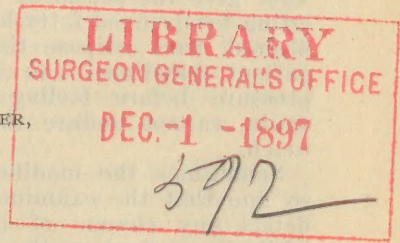
April 25, 1896.

On Cellulitis or Panniculitis Adiposa and Myitis Occurring as Usual Complications to Gynecological Diseases.

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Cellulitis—as the word is used here—signifies inflammation of the adipose tissue; it is, if I may so describe it, a panniculitis adiposa. Therefore it is not a question of pelvic cellulitis. To avoid a misunderstanding it would be better if one of these two, so-called cellulitis, could receive another name, but on the other hand, one cannot be easily misunderstood in speaking of the one or the other, for the connecting circumstances show clearly enough which is meant. The word cellulitis in the sense of panniculitis adiposa has won its abode in medical terminology as well as the idea of pelvic cellulitis; therefore, I will retain it.

It is fully 15 years since Dr. Mauritz Salin, professor in gynecology in Stockholm, Sweden, demonstrated cellulitis, or as I should prefer to call it panniculitis adiposa, and, although he has constantly since then presented it to his pupils, it is not mentioned in medical literature, to my knowledge, except by Drs. C. D. Jos-

ephson and A. Kjellberg, both of Stockholm, of whom the former described the disease in Hygeia some years ago, the latter in Eira, both journals published in Stockholm.

The symptoms of cellulitis are subjective and objective.

The subjective ones are partly sensations of pain, partly nervous symptoms resulting therefrom. The invalid complains according to locality and intensity, of ill-defined, uncomfortable feelings of numbness, creeping, stiffness, lassitude, etc., in certain parts of the body, which change to tenderness on motion; pain from pressure, aching, difficulty in lying, in sitting, feelings of "something pressing down," etc., it being impossible to bear the touch of clothing, especially in cases of abdominal cellulitis. The patient often complains of a swelling of the bowels, and in pectoral cellulitis of difficulty in breathing. In short, complaints are made of a great number of dissimilar symptoms, most resembling so-

called rheumatism, to which may be added, in case of long-continued and extended cellulitis in a person disposed to it, depression, unrest, anxiety, irritability, in short, a number of neurasthenic symptoms of depression, which must be truly trying both for the patient and for those associated.

The most common objective symptoms are modified consistency of the subcutaneous adipose tissue, which on tapping with the fingers seems to be less elastic and more lumpish than formerly; moreover, it is rather indurated. One can feel the small fat lobules and fat cells plainer than usual (can sometimes see them distinctly indicated through the skin). They give the sensation of manipulating firmly fixed fatty lobuli or infiltrated, hard adipose tissue. The patient sometimes can bear some pressure before feeling pain, but again, cannot endure the slightest touch.

Sometimes the modifications are so fine that the examiner does not detect any change of consistency, while the patient, on the contrary, is very sensitive to its hurting. The size of such an infiltrated adipose tissue varies from a little grain in the healthy tissue to a continuous patch as broad as two palms of the hand and the locality as well as the distribution also varies greatly.

Cellulitis can appear simultaneously in several parts of the body, widely separated from each other, when it is called "general cellulitis," or it is found only in one or two spots and is called "local cellulitis." Scarcely any subcutaneous adipose tissue exists in which I have not found some evidence of inflammation from the scalp to the soles of the feet, but it appears most frequently in the abdomen (60 to 70 per cent.), below and beside the navel, in the sides—perhaps most frequently the left side—in the lumbar region, besides in regio pubis. One finds the nodules in the back and the breast, in the arms and legs, in the scapular and gluteal regions, and here, as in the abdomen, most frequently causing a slight swelling of the affected part.

The diagnosis is generally easy and

is founded on the subcutaneous position, tenderness and manipulative discoveries. The best way for manipulation is to grasp the skin and subdermis firmly between the thumb, middle and ring fingers of both hands, lift the subcutaneous tissue up and at the same time roll it between the fingers. In case of more extended cellulitis, one grasps the skin and lifts it up with the whole hand, with the thumb, thenar and hypnothenar on one side and the inner surface of the outstretched fingers on the other side, and in this position roll or systematically press the tissue.

A differential diagnosis is hardly worth speaking of before a conscientious examiner. Only myites and edema can come into consideration. Myitis, however, lies deeper and cannot be detected by touch, while lifting the skin and subcutaneous tissue only. Edema is more pliable, more evenly distributed, not lobulated, not tender to the touch and more doughy.

It is very easy for a superficial or one-sided examiner to be mistaken as to the nature of the disease and still more so for the patient himself. For this reason one hears of gastritis, uterine displacement, appendicitis, bladder trouble, heart failure, pleurisy, etc., according to the locality of the pain, not to speak of rheumatism, influenza, hysteria, affection, laziness, and what not.

The duration of the disease becomes chronic as a rule, with a beginning frequently unmarked. The patient can have cellulitis for years without knowing it. It may become acute or is discovered by accident. The symptoms can come and go like ordinary muscular rheumatism, but once subjectively established, they remain, often obstinately, and then leave the patient no rest. If seldom begins acutely or disappears hastily. Once I have, however, seen acute developments during a course of treatment, as a result of taking cold, which disappeared in a couple of days.

Treatment.—This consists chiefly in massage, which in many cases is introduced with advantage by means of vibrations with Liedbeck's vibra-

tor, and which massage is applied nearly the same as the palpatory manipulation; that is to say, the cutis and subcutaneous tissue are lifted and one tries, without losing hold, to roll, knead and press asunder the inflammatory products. A trace of salve blended with lanoline is applied to the skin. P. H. Ling, founder of the system of medical gymnastics and scientific massage, says "too little can be increased, but too much cannot be reduced," and this applies especially to massage for cellulitis, which can produce harmful results and have to be abandoned if it is taken up too vigorously. Some patients are in beginning so sensitive to touch that they shrink from even the thought of it, complain if the hand is laid ever so lightly on the affected part; others, on the contrary, can bear quite strong handling, and especially after the first treatment. Sometimes a full cure can be effected and the patient freed from all subjective (sometimes also objective) symptoms, and without a relapse. Again, the health returns, but only for a few months or years. Another massage treatment will then relieve the patient for a longer or shorter time. In very obstinate cases there is seldom any improvement at all. Many patients become well after a couple of weeks' treatment; others only after several months' daily massage. If the masseur is too rough in his handling, he can expect nothing but a failure. Be he too light-handed, he will not succeed either; but he has this in his favor, that he accustoms the patient in the beginning and prepares him for as strong treatment as necessary.

Prognosis.—This depends, on the rule already given—*quoad salutem completam incertum; quod solutem incompletam bonam*—because even the worst form of cellulitis can generally become tolerable after a lengthy treatment or disappear almost entirely.

As to the appearance of this sickness, it is much more frequently met among women than men, and most often among the poor. It appears among people of all ages, from, ac-

cording to Dr. Kjellberg's tables, "under 10 years of age to over 50." Moreover, it is probably spread over the whole globe. I have found it in Europe, from England to the heart of Russia (Moscow), also from the north of Sweden to France and Southern Germany, as well as in America.

When we consider how often women are improperly clothed, many times in "open drawers," or among the poor often in none at all, and further consider that abdominal cellulitis is the most frequent form, there can be no doubt that so-called "taking cold" is the most common cause of the disease. My case, No. 1, of a person who "took cold" during treatment and was seized with an acute form, is an illustration. Another probable cause is a long-continued or oft-recurring mild form of trauma, or a short, violent form. For instance, the pressure of skirt bands or corsets, leaning against a wash tub, blows, etc.

"The only fact," says Dr. Kjellberg, "which is worth mentioning in regard to etiology is the relation of fat and of nervousness. It is usually fat persons, who are also nervous, that have cellulitis. That fat persons are most exposed to it is not strange, as it is just in fatty tissue the disease locates. The connection between nervousness and cellulitis is more difficult to explain; but one can perhaps explain it in this way: that a person with cellulitis does not feel well and the abnormal sensations which cellulitis occasions, must sooner or later cause nervousness."

As to pathogenesis a microscopic examination does not seem to have been made, but judging from the manifestations of the disease, it depends on exudations or inflammation, with the formation of connective tissue, in the region of the subcutaneous fat, especially the interlobular or intercellular one, perhaps also an analogous change in the fat cells themselves and their protoplasmic membranes.

After this description of cellulitis now the question might well be asked, "Why, or of what interest is it to gynecologists?"

Some records ought to explain:

Case I. Mrs. T., 48 years old, fell down backwards 29 years ago; laid in bed 14 days afterwards; treated with massage of the back. A couple of years later was troubled with frequent "passing of urine," which also was treated with massage of the back and abdominal compresses. Recovery followed soon. She married 20 years ago, and had only one child, now 19 years old; was obliged to lie in bed two months after confinement. Menses always regular, never absent except during pregnancy, and the time immediately following. Has suffered from leucorrhea even since confinement, until a couple of years ago, when it, together with the menses, ceased. Says she has always been careless of her health and never saved herself. Has always worn "open drawers." Her health, which was good before marriage, has gradually failed, and for the last four years has been in a low state. During this time she has been troubled with gastric symptoms and rheumatoid pains, sometimes in the legs, but mostly in the abdomen, just over the left groin. She walked with difficulty and preferred to sit still. "Something has seemed to fall down once in a while," she says, indicating the uterine region. She has not been able to endure a corset, and has slight pain in the back if attempting to lie on it. She has become more nervous and irritable; evacuation scarcely once a week. She has been ashamed to seek a physician, but her condition finally forced her to it.

Status praes. 10 Feb.—Spirits depressed. Flesh good; particularly strong development of fatty tissue in the abdomen. Skin or rather panniculus adiposus is so tender for a space beginning an inch left of spina lumbalis over the whole left side of dorsum abdominale and the front of left abdomen to near the navel line, that the patient complains loudly at the least touch. On manipulating the fatty tissue here can be felt—as is partly visible to the naked eye—indurated fat lobules. On the corresponding right side an indication of the same change is to be found,

but the parts are not painful, when moderately pressed. The knees are rather larger, with thickened synovial membrane; uterus double natural size, hard and bent forward, without cervix erosion. No prolapse of the womb or of the vagina. The left parametrium, ovarium and surroundings somewhat infiltrated and very tender. In the right ovary or ligamentum there was a fibrous tumor as large as an orange, scarcely tender.

Treatment of this case.—Vibrations on the back, ordinary massage of the anterior abdominal region, also "cellulitis massage" and so-called gynecological massage of the uterus, the left ovarian region and left parametrium. At first the treatment was confined to the vibrator and "abdominal massage." From the third day cellulitis and "gynecological massage" could be employed, and improvement began to be so rapid that after the third week the patient could walk two miles and back, and had an evacuation nearly every day. One day during the fourth week of treatment she declared herself perfectly well, and I found it necessary to continue treatment only one week longer, when there suddenly came a hindrance to improvement. The weather, which had previously been summer like, though in the middle of winter, suddenly changed and a north wind and snow storm set in. The patient was out and was nearly blown down; she thought she would never be able to get home, and she plainly felt the wind blow up through the "open drawers." The following day the patient presented nearly the same appearance as at the beginning of the treatment. The cellulitis, which had nearly disappeared, reappeared, hard, tender and knotty, as before. Besides this the patient complained of nausea and stomach ache, and the intestines bloated with gas. After three days' treatment as before with ordinary abdominal and cellulitis massage, the patient felt well again, and the cellulitis had in a great degree disappeared. It is scarcely necessary to add that after this attack the patient hastened to

obey the order to clothe herself in warm drawers. When discharged the uterine trouble remained almost unchanged, and still the patient felt fully recovered.

Case II. Mrs. P., 28 years of age; has three children, 8, 6 and 4 years old; says she got uterine difficulty after the last confinement; has constant pain and weakness in the back; radiating down the legs; pain in stomach and down through the groins; fluor albus; regular menses; sometimes frequent urination. During a long railroad journey a couple of years ago, she "caught cold" and could not retain her urine. Treatment for it and for uterine trouble (locally) was given by a celebrated gynecologist in the West, with partially good results, although the weakness of the back continued. Returning to Boston she sought a well-known surgeon, who treated her for several weeks, by "packing the vagina" and local uterine applications, but without any apparent improvement.

Status praes.—Uterus enlarged; tender to the touch; somewhat more fixed than normal; muco-purulent secretion covering the corroded cervix opening. On the abdomen extended cellulitis and myitis, and nearly the whole erectores spinae were affected, but principally in the lumbo dorsales, also the glutei.

The treatment consisted in massage of the uterus, the cellulitis, the abdomen and the diseased muscles. After three weeks the myitis had almost disappeared, flowing had ceased and the size of uterus had somewhat decreased. The abdomen had diminished, so that the patient had to "take in" her garments, but the weakness in the back was still felt if the patient strained herself over chamber work, etc. After two more weeks of treatment, the myitis was entirely gone, and after 31 treatments the patient could be called well. At present, a half year or more having elapsed, she remains well, and has resumed all the work of her household.

From the above cases it would appear that myitis simulates gynecologi-

cal diseases or is at times a complication.

Myites which can be symptomatically taken for uterine trouble are those forms that on account of their location in the abdomen, pelvis, or adjacent parts, cause the patient to attribute the trouble to some genital organ; or whose symptoms also correspond with those of some gynecological diseases. Inflammation, in the muscles, now under consideration, often causes pain radiating from the back down into the lumbar region, into the abdomen, or from the lumbar region down the legs. The pain radiates through certain lines or is more or less diffuse and remains obstinately, or goes and returns like "rheumatism." Sometimes they are felt most on walking; sometimes after extra work, and so on; in short, on occasions where the muscles are set into relatively too hasty action, or have been too much strained. By the subjective symptoms, therefore, one can often decide on the location of the myitis, a supposition that is fully borne out by palpation, because the patient always finds out "punete dolorose," even if the physician could not detect them by the changed consistence of the muscles. Besides these local sensations of pain, one often discovers reflex pains, most frequently attributed by the patient to the uterus or its vicinity. The result is that whenever the patient has got the idea by herself or has been told by a physician of an otherwise subjectively symptomless gynecological affection, she is convinced that all her aches proceed therefrom. The subjective symptoms of cellulitis, myitis and some gynecological diseases can be so similar, that frequently it is only by objective examination and sometimes only the results from treatment one can determine their origin.

The subjective symptoms of gynecological diseases which are most analogous to cellulitis and myitis are those from metritis, endo-, peri- or parametritis, oophoritis, and sometimes in irritable persons from cystitis.

There is no doubt, when cellulitis and myitis complicate a gynecologi-

cal disease, that the categorical symptoms of both diseases increase each other just as one wave can increase another, but it is just as certain that gynecological diseases can be symptomless and that all subjective inconvenience may come from complications, because when the latter are removed, the quasi-gynecological symptoms cease. This has been shown in the cases above cited. The myitis toward which, as gynecologists, we have to direct our attention to, most frequently are those forms in the lumbo-dorsal and gluteal regions; in the latter case, especially, at the origin of *gluteus medius*, sometimes those in the abdominal and hip muscles, as also, less frequently, in *psoas* muscles.

Myitis can depend, as well as cellulitis and gynecological diseases, partly on changes of temperature, but the most common are, however, overdoing and trauma.

If we were to attribute to myitis every muscular change not due to neoplasm or a similar cause, then we must refer to it contractions, whose cause is partly myopathic, partly neuropathic, and furthermore we should have to refer it to *contractura ani*, which often complicates a gynecological disease, yet whose treatment cannot come under the same head as the other myitis.

As to chronic inflammation in muscle *psoas*, it is a so very seldom noticed disorder, that hardly anyone thinks about it, and still it is important enough. It can simulate much more than is here treated of. For myself, I have only once formed a diagnosis upon it, namely in a case of chronic appendicitis, in which the patient, a man, 40 years old, was operated upon successfully. After the operation mild pains remained in the cecal region, pains which I considered were due to infiltration. They were felt in the lower portion of the *psoas magnus dextra*, and disappeared with the infiltration, after several months' daily treatment with massage. The cause of both appendicitis and *psoas myitis* was in this case probably a trauma of 23 years before, when as a youth, a large stone

rolled over the stomach of the patient.

In medical literature I have succeeded in finding only one author who names *psoas myitis*, and that is Dr. E. W. Wretling, of Stockholm, who tells of five cases. I will take the liberty to relate briefly three of these cases, which are of interest to the subject of to-day.

Case III. Mrs. H. H., 33 years old, has suffered in "lower part of bowels" for some years, her suffering increased noticeably by daily labor, with pains in the back, that shot up towards the heart, and occasionally caused palpitation. The patient is anemic and troubled with fatigue in arms and legs. Menses abundant and long continued; the lips of *os uteri externum* eroded. Palpation produced tenderness in various parts of the abdominal wall as well as in both "*psoas* muscles." After six weeks' treatment, chiefly with daily massage of abdominal wall and *psoas* muscles, the patient felt well.

Case. IV. Mrs. F. G., 51 years old, was anemic, overworked, suffered from *anteflexio uteri*, and *fluor albo*, with periodic pains in lower part of abdomen, also dysuria. During the first two years these pains were thought to be due to uterine disease. But on closer examination it was found that the pain in the lower part of abdomen felt "as if it was in the small intestines," radiating towards the back and down the inside of the thighs. During the pain the patient had "difficulty in bending forward." The *psoas* muscles were noticeably harder, for which reason they were treated for three weeks with massage, when the tenderness decreased. The dysuria remained.

Case V. Miss A. S., 52 years old, had acquired the habit of morphine by trying to deaden unbearable, frequently recurring, abdominal pains. This painful trouble had been brought on while taking care of a near sick relative, who required much lifting. Abdominal pains came often and sometimes without apparent cause; but usually after a bodily strain, or an evacuation of the bowels, which was particularly difficult. Sleep bad; menses irregular.

The examination discovered partly a contractureⁱⁿ and partly a very marked tenderness over both muscoli psoas.

Besides a "dilatation forcée" and a mild bath treatment, she had daily massage of the abdomen and of the muscoli psoas, resulting in almost a complete recovery. The morphine habit was overcome by constantly decreasing doses under hypnotic suggestions.

The above related cases are only a few, but they show that cellulitis and myitis occur with gynecological diseases. In my practice such a complication has happened in about 50

per cent. Very often both cellulitis and myitis occur at the same time. They will be found more frequent among poor people; cellulitis alone in greater percentage among fat persons.

What has been said is sufficient to show the importance of cellulitis or panniculitis adiposa and of myitis as common complications of gynecological diseases, and as both are best treated with massage and often will not yield to any other form of therapy, they form another reason why gynecologists should not forget massage as among the valuable methods of treatment.



